

EMPLOYER RESPONSE—MEDICAL SEPARATION

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S
ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE.

Date: _____

Claimant Name: GRANGEVILLE LOCAL OFFICE IDAHO DEPARTMENT OF LABOR PO BOX 550 GRANGEVILLE ID 83530-0550 208-983-0302 (FAX)		SSN: Employer's Name, Address, Phone & Fax	
Paid or to be paid:			
Gross earnings for the past 12 months \$		Severance: \$	On (date):
Vacation: \$		Bonus: \$	On (date):
Date payment will be received:		Holiday: \$	On (date):
Rate of Pay per hour: \$		Pension or Retirement pay was paid or will be paid:	
		\$	On (date):
Supervisor's Name:		Employer's Phone#:	
Start Date of Employment:		Last Day worked:	
Date of Separation: _____			
Do you have a leave policy for employees who are unable to work? Yes <input type="checkbox"/> (Please provide copy) No <input type="checkbox"/>			
Did the claimant discuss the possibility of a leave with you? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Briefly explain your leave policy. Are you holding the claimant's job for him/her? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If the claimant is on a leave beginning date _____ ending date _____			
Did claimant discuss the possibility of other work with you? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you have other work, which would accommodate the claimant's limitations? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Position:		Hours per day:	Rate of Pay:
If yes, did you offer this work to the claimant? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, why not?			
Did the claimant provide you with verifiable information (Medical statement—visual observation) of his/her ability to work? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____			
Please provide any additional information you believe should be considered in determining claimant's eligibility. <i>NOTE: PLEASE ATTACH ANY RELATED DOCUMENTATION TO SUPPORT YOUR POSITION</i> For example written warnings, policy manuals, time cards, personnel records, statements from first-hand witnesses, written customer complaints, police reports, and other evidence to support your statement(s)			
Employer/Employer's Representative Signature: _____			
Print Name: _____		Title: _____	
Phone Number: _____		Date: _____	